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In The

Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska, et al., *Petitioners*,

v.

LEROY CARHART, M.D., *Respondent*.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

Brief of Amici Curiae U.S. Rep. Charles T. Canady and Other Members of Congress in Support of Petitioners
(listed inside front cover)

James Bopp, Jr.
Richard E. Coleson
Counsel of Record
Thomas J. Marzen
BOPP, COLESON & BOSTROM
1 South 6th Street
Terre Haute, IN 47807-3510
(812) 232-2434
Counsel for Amici Curiae

February 28, 2000

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AMICI CURIAE – MEMBERS OF CONGRESS

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Planned Parenthood of S.E. Pennsylvania v. Casey, 505 U.S. 833 (1992) ..... *passism*

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Showery v. Texas, 690 S.W.2d 689 (Tex. Ct. App. 1985) 21

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Women's Med. Prof. Corp. v. Voinovich, 911 F. Supp. 1051 (S.D. Ohio 1995) 7

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Cong. Rec. S18228, roll call #596 (Dec. 7, 1995) 11

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Cong. Rec. H3338-3339, H. Doc. 104-198 (Apr. 10, 1996) 11

Cong. Rec. H10642, roll call #422 (Sept. 19, 1996) 11

Cong. Rec. S11337-11361, roll call #301 (Sept. 26, 1996) 11

Cong. Rec. H1231, roll call #65 (Mar. 20, 1997) 12

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Cong. Rec. H6212-13, roll call #325 (July 23, 1998) 12

Cong. Rec. S10564, roll call #227 (Sept. 18, 1998) 12

Cong. Rec. S11356 16

Cong. Rec. S11375 17

Cong. Rec. S12997, roll call #340 (Oct. 21, 1999) 17

Partial-Birth Abortion Ban Act of 1995, H.R. Rep. No. 104-267 (1995) 3, 10, 20, 27

The Partial-Birth Abortion Ban Act of 1995: Hearing on H.R. 1833 Before the Senate Comm. on the Judiciary, 104th Cong. (Nov. 17, 1995) 3-7, 19

Partial-Birth Abortion Ban Act of 1997, H.R. 1122, 105th Cong., § 1531 (a) & (b) (Oct. 9, 1997) 12-13

Partial-Birth Abortion Ban Act of 1999, S. 1692, 106th Cong. (Oct. 21, 1999) (Engrossed in Senate) 17-19

Partial-Birth Abortion: Hearing Before the Subcomm. on the Constitution of the House Comm. on the Judiciary, 104th Cong. 110-15 (June 15, 1995) 8-9, 16

Partial-Birth Abortion: The Truth: Joint Hearing on S. 6 and H.R. 929 Before the Sen. Comm. on the Judiciary and the Subcomm. on the Constitution of the House Comm. on the Judiciary, 105th Cong. 56 (1997) ... 13

Other Authorities

American Heritage College Dictionary (1993) 2, 23

Black's Law Dictionary (5th ed. 1979) 23

James Bopp, Jr., J.D. & Curtis R. Cook, M.D., *Partial-Birth Abortion: The Final Frontier of Abortion Jurisprudence*, 14 Issues in Law & Medicine 3 (1998) 2

Brief of Amici Curiae Alabama, Iowa, Louisiana, et al. in Support of Petitioners at 16 n.11, *Stenberg v. Carhart*, No. 99-830 (this case; brief supporting cert.) 3

Mary Campbell, *H.R. 1833: Medical Questions and Answers* (October, 1995) 15

Congressional Quarterly, *Moynihan: Clinton turnabout likely Senator says veto OK'd infanticide*, CQ's Washington Alert, March 15, 1997, Item 1 17

Ann Devroy, *Late-Term Abortion Ban Vetoed*, Wash. Post, Apr. 11, 1996, at A1 14

Katherine Dowling, *What Constitutes A Quality of Life?: Neither Treatable Conditions Nor Permanent Handicaps Mean People Can't Live Useful, Happy Lives*, L.A. Times, Aug. 28, 1996 10

Diane M. Gianelli, *Anesthesiologists Question Claims in Abortion Debate*, Am. Med. News, Jan. 1, 1996, at 4 15

Diane M. Gianelli, *Medicine Adds to Debate on Late-Term Abortion: Abortion Rights Leader Urges End to 'Half Truths,'* Am. Med. News, Mar. 3, 1997, at 3 . 11

Martin Haskell, M.D., *Dilation and Extraction for Late Second Trimester Abortion* (monograph presented at the National Abortion Federation's two-day Fall Risk Management Seminar entitled *Second Trimester*

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David Stout, *An Abortion Rights Advocate Says He Lied About Procedure*, N.Y. Times, Feb. 26, 1997, at A12 12

Sutherland on Statutory Construction (rev. 5th ed. 1992) . . 2

Tex. Att'y Gen. Opinion H-369 (Aug. 13, 1974) 21

INTEREST OF AMICI CURIAE[1]

Amici Curiae are members of the United States Congress who have been key sponsors of legislation to ban partial-birth abortion.

SUMMARY OF THE ARGUMENT

Nebraska's partial-birth abortion ("PBA") ban is directly patterned after a 1997 bill in Congress, a refinement of a 1995 bill, making the federal bills in pari materia for construing Nebraska's law. The history of congressional efforts to ban PBA shows that only a new procedure was targeted – one publicized by Dr. Martin Haskell and now also known as intact dilation and extraction ("intact D&X") – not conventional abortion methods. The federal bills received support even from prominent members of Congress who identify themselves as pro-choice – further indicating both that there was no congressional intent to ban conventional abortions and that PBA is beyond what most Americans perceive as "abortion." It would be a radical extension of *Casey* to expand it to reach a partial-birth killing procedure that Congress (along with most Americans and States) does not even consider to be "abortion."

The federal PBA bills were founded on the premise that the change in the partially-born child's location triggers heightened state interests in protecting the child and that this

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[1]**Rule 37.6:** Amici Curiae disclose that (1) no counsel for a party authored this brief in whole or in part and (2) the National Right to Life Committee made a monetary contribution to the preparation and submission of this brief. **Rule 37.3(a):** Petitioners and Respondent consented to the filing of this brief. Consent letters have been provided to the Clerk.

Court's abortion jurisprudence does not govern "parturition,"[2] but only situations where a child is "unborn." The federal PBA bill was also premised on the congressional finding, after extensive testimony, that the PBA procedure is never medically indicated and that there are conventional abortion procedures that do not involve the killing of a living, partially-born child. Therefore, even if this Court's abortion decisions apply in the PBA context, there is no undue burden.

ARGUMENT

I. The History of Congressional Efforts to Ban Partial-Birth Abortion Reveals That Only the Intact D&X Procedure Was Targeted.

Nebraska's PBA ban is patterned after a 1997 bill passed by both houses of the United States Congress.[3] This makes the Nebraska ban in pari materia with the federal bill for purposes of determining the targeted activity and historical context of the Nebraska ban. *See, e.g., Michigan Nat'l Bank v. Michigan* 365 U.S. 467 (1961) (federal Home Owner's Loan Act of 1933 held to be in pari materia with subsequently enacted Michigan savings and loan tax statute). *Cf.* 2 *Sutherland on Statutory Construction* § 53.03 (rev. 5th ed. 1992) ("[T]he interpretation of a doubtful statute may be influenced by language of other statutes which are not specifically related, but which apply to similar persons, things, or relationships.")

A prior version of the federal bill was passed by both houses of Congress in 1995. Many state legislatures have followed the pattern of these two bills and passed bills barring *partial-birth abortion*, a legal term of art for a procedure in which a living intact infant is partially, vaginally delivered, then killed before being completely removed from the birth canal.

When the described procedure became widely known in 1994, there was immediate controversy. Legislative efforts to ban it began in June 1995. Congressional hearings were held, and a federal bill was passed and vetoed by President Clinton with much publicity. *See Partial-Birth Abortion Ban Act of 1995*, H.R. Rep. No. 104-267 (1995). Nearly two-thirds of the States have enacted bills patterned after the federal bills.[4]

A. *Dr. Haskell Ignited the Controversy.*

On September 13, 1992, Dr. Martin Haskell, an abortion provider who operates three abortion clinics, presented *Dilation and Extraction for Late Second Trimester Abortion* (hereinafter "*Haskell Monograph*"), at the National Abortion Federation's two-day Fall Risk Management Seminar (Dallas, Texas) entitled *Second Trimester Abortion: From Every Angle* (appended as *Appendix A*). The monograph and numerous other materials on PBA were collected and published as the record of hearings before the U.S. Senate Judiciary Committee on the Partial-Birth Abortion Ban Act of 1995. *See The Partial-Birth Abortion Ban Act of 1995: Hearing on H.R. 1833 Before the Senate Comm. on the Judiciary*, 104th Cong. 3 (Nov. 17, 1995) [hereinafter "*1995 Senate Hearings*"].

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[2]"Parturition" is "the action or process of giving birth . . . ." *American Heritage College Dictionary* 997 (1993).

[3]*See also* James Bopp, Jr., J.D. & Curtis R. Cook, M.D., *Partial-Birth Abortion: The Final Frontier of Abortion Jurisprudence*, 14 Issues in Law & Medicine 3 (1998).

[4]*See* Brief of Amici Curiae Alabama, Iowa, Louisiana, et al. in Support of Petitioners at 16 n.11, *Stenberg v. Carhart*, No. 99-830 (this case; brief supporting cert.) (listing states enacting PBA bans).

In his paper, Dr. Haskell, who has done over 1,000 partial-birth abortions, described a procedure in which he used ultrasound guidance to partially extract a living fetus feet-first, then punctured the baby's skull and suctioned the cranial contents before completing the extraction. *See id.* at 7-8 (*Haskell Monograph*). He described the procedure as "a quick, surgical outpatient method that can be performed on a scheduled basis under local anesthesia." *Id.* at 11. Dr. Haskell (a family practitioner, not an obstetrician-gynecologist) wrote that he "routinely performs this procedure on all patients 20 through 24 weeks" (4½ to 5½ months) pregnant, but excludes women who are more than 20 pounds overweight, have twins, or have certain other complicating factors. *See id.* at 6-7.

Dr. Haskell provided precise detail of the critical part of the procedure:

> With a lower [fetal] extremity in the vagina, the surgeon uses his fingers to deliver the opposite lower extremity, then the torso, the shoulders and the upper extremities.
>
> The skull lodges at the internal cervical os. Usually there is not enough dilation for it to pass through. The fetus is oriented dorsum or spine up.
>
> At this point, the right-handed surgeon slides the fingers of the left hand along the back of the fetus and "hooks" the shoulders of the fetus with the index and ring fingers (palm down). . . . [T]he surgeon takes a pair of blunt curved Metzenbaum scissors in the right hand. He carefully advances the tip, curved down, along the spine and under his middle finger until he feels it contact the base of the skull under the tip of his middle finger.
>
> Reassessing proper placement of the closed scissors tip . . . the surgeon then forces the scissors into the base of the skull or into the foramen magnum. Having safely entered the skull, he spreads the scissors to enlarge the opening.
>
> The surgeon removes the scissors and introduces a suction catheter into this hole and evacuates the skull contents. With the catheter still in place, he applies traction to the fetus, removing it completely from the patient.

Id. at 8-9.

In a 1993 interview with *Cincinnati Medicine*, Dr. Haskell explained why he had adopted the method. He had been performing dismemberment abortions (D&Es) to 24 weeks:

> But they were very tough. Sometimes it was a 45-minute operation. I noticed that some of the later D&Es were very, very easy. So I asked myself why can't they all happen this way. You see the easy ones would have a foot[ling] presentation, you'd reach up and grab the foot of the fetus, pull the fetus down and the head would hang up and then you would collapse the head and take it out. It was easy. . . . Then I said, "Well gee, if I just put the ultrasound up there I could see it all and I wouldn't have to feel around for it." I did that and sure enough, I found it 99 percent of the time. Kind of serendipity.

Second Trimester Abortion: An Interview With W. Martin Haskell, M.D., 16 Cincinnati Med. 18, 19 (1993).

In 1993, the *American Medical News* – the official newspaper of the AMA – conducted a tape-recorded interview with Dr. Haskell concerning this specific abortion method in which he indicated that two-thirds of the partially-born children

on which he performed his procedure were not dead before he began to remove them:

> **Am. Med. News:** Let's talk first about whether or not the fetus is dead beforehand . . .
>
> **Haskell:** No it's not. No, it's really not. A percentage are for various numbers of reasons. Some just because of the stress – intrauterine stress during, you know, the two days that the cervix is being dilated. Sometimes the membranes rupture and it takes a very small superficial infection to kill a fetus in utero when the membranes are broken. And so in my case, I would think probably about a third of those are definitely are (sic) dead before I actually start to remove the fetus. And probably the other two-third are not.

1995 Senate Hearings at 22-24 (Letter from Barbara Bolsen (Editor of *American Medical News*) to the Hon. Charles T. Canady (Chairman, Subcomm. on the Constitution, Comm. on the Judiciary) (July 11, 1995) (attaching transcript of interview with Dr. Haskell from which quotation was taken)).

Concerning the possibility of simply delivering the child alive, Dr. Haskell indicated that such a result was a possibility, but that it was not his goal:

> The point here is to effect a safe legal abortion. . . . I could put dilapan in for four or five days and say I'm doing a D&E procedure and the fetus could just fall out. But that's not really the point. The point here is you're attempting to do an abortion. And that's the goal of your work, is to complete an abortion. Not to see how do I manipulate the situation so that I get a live birth instead.

Id. at 23.

Dr. Haskell also indicated that the overwhelming number of his partial-birth abortions were elective:

> And I'll be quite frank: most of my abortions are elective in that 20-24 week range. . . . In my particular case, probably 20% [of this procedure] are for genetic reasons. And the other 80% are purely elective.

Id.

In a lawsuit in 1995, Dr. Haskell testified that women come to him for partial-birth abortions with "a variety of conditions. Some medical, some not so medical." *Id.* at 28 (Transcript of testimony of Dr. Haskell on Nov. 8, 1995, *in Women's Med. Prof. Corp. v. Voinovich*, 911 F. Supp. 1051 (S.D. Ohio 1995)). Among the medical examples he cited was "agoraphobia" (fear of open places). *See id.* at 29. Moreover, in testimony presented to the Senate Judiciary Committee on November 17, 1995, OB/GYN Dr. Nancy Romer of Dayton (a city in which Dr. Haskell operates an abortion clinic) testified that three of her own patients had gone to Haskell's clinic for abortions "well beyond" five months into pregnancy, and that "[n]one of these women had any medical illness and all three had normal fetuses." *Id.* at 109 (statement of Nancy G. Romer, M.D.).

Brenda Pratt Shafer, a registered nurse who observed Dr. Haskell use the procedure to abort three babies in 1993, testified that one little boy had Down's syndrome, while the other two babies were completely normal and their mothers were healthy. *See id.* at 18-19 (statement of Brenda Pratt Shafer, R.N.). In 1995 testimony before the U.S. Senate Judiciary Committee, she described a partial-birth abortion she witnessed on a child of 26½ weeks as follows:

> Dr. Haskell brought the ultrasound in and hooked it

up so that he could see the baby. On the ultrasound screen, I could see the heart beat. As Dr. Haskell watched the baby on the ultrasound screen, the baby's heartbeat was clearly visible on the ultrasound screen.

Dr. Haskell went in with forceps and grabbed the baby's legs and pulled them down into the birth canal. Then he delivered the baby's body and the arms – everything but the head. The doctor kept the head right inside the uterus. . . .

The baby's little fingers were clasping and unclasping, and his little feet were kicking. Then the doctor stuck the scissors in the back of his head, and the baby's arms jerked out, like a startle reaction, like a flinch, like a baby does when he thinks he is going to fall.

The doctor opened up the scissors, stuck a high-powered suction tube into the opening, and sucked the baby's brains out. Now the baby went completely limp. . . . That baby boy had the most perfect angelic face I think I have ever seen in my life.

Id. at 18.

Dr. Haskell's intact D&X procedure was the clear target of congressional efforts to ban partial-birth abortion. A drawing of the procedure was used in the hearings and recurs in congressional hearing records. *See, e.g., Partial-Birth Abortion: The Truth: Joint Hearing on S. 6 and H.R. 929 Before the Sen. Comm. on the Judiciary and the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 105th Cong. 56 (1997) (appended as *Appendix B*).

B. *Dr. McMahon Fueled the Conflict.*

The late Dr. James McMahon performed thousands of

partial-birth abortions. Dr. McMahon's writings cite a number of indications for performing the D&X procedure "for health reasons": cleft lip, 2 vessel cord (most commonly associated with a normal infant), too little or too much fluid (variations from the norm are not uncommon, and typically not associated with birth defects), exposure to a teratogen (a substance that can cause a birth defect, of which most have a low probability for effect), etc. He also cites depression, minor maternal complications, and even a small pelvis as separate indications to kill the baby in advanced gestation. *See Partial-Birth Abortion: Hearing Before the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 104th Cong. 110-15 (June 15, 1995) [hereinafter "*Partial-Birth Abortion*"] (Appendix 3 – Letter from Jim McMahon, M.D., to Keri Harrison (assistant counsel, Subcommittee on the Constitution) (June 8, 1995) (attaching charts of "Fetal Indications" for abortions he performed)).

Dr. McMahon also gave testimony about the reasons why he does partial-birth abortions. In June, 1995, Dr. McMahon submitted to Congress a detailed breakdown of a "series" of over 2,000 of these abortions that he had performed. He classified only 9% (175 cases) as involving "maternal [health] indications," of which the most common was "depression." *Id.*

Dr. Pamela E. Smith, director of Medical Education, Department of Obstetrics and Gynecology, Mt. Sinai Hospital, Chicago, gave the Senate Judiciary Committee her analysis of Dr. McMahon's 175 "maternal indication" cases. Of this sample, Smith noted that 39 cases (22%) were for maternal "depression," while another 16% were "for conditions consistent with the birth of a normal child (e.g., sickle cell trait, prolapsed uterus, small pelvis)." She added that in one-third of the cases, the conditions listed as "maternal indications" by Dr. McMahon really indicated that the procedure itself would be

seriously risky to the mother. *1995 Senate Hearings* at 82 (prepared statement of Pamela Smith, M.D.).

Of Dr. McMahon's series, 1,183 cases (about 56%) were for "fetal flaws," but these included a great many non-lethal disorders, such as cleft palate and Down's syndrome. *See Partial-Birth Abortion* at 110-15. In an op ed piece written for the *Los Angeles Times*, Dr. Katherine Dowling, a family physician at the University of Southern California School of Medicine, examined Dr. McMahon's report on this "fetal flaws" group:

> Twenty-four were done for cystic hy[g]roma (a benign lymphatic mass, usually treatable in a child of normal intelligence). Nine were done for cleft lip-palate syndrome (a friend of mine, mother of five, and a colleague who is a pulmonary specialist were both born with this problem). Other reasons included cystic fibrosis (my daughter went through high school with a classmate with cystic fibrosis) and duodenal atresia (surgically correctable, but many children with this problem are moderately mentally retarded). Guess they can't enjoy life, can they? In fact, most of the partial-birth abortions in that [McMahon] survey were done for problems that were either surgically correctable or would result in some degree of neurologic or mental impairment, but would not harm the mother. Or they were done for reasons that were pretty skimpy: depression, chicken pox, diabetes, vomiting.

Katherine Dowling, *What Constitutes A Quality of Life?: Neither Treatable Conditions Nor Permanent Handicaps Mean People Can't Live Useful, Happy Lives*, L.A. Times, Aug. 28, 1996, at B9.

C. *Congress Reacted with a Ban on Partial-Birth Abortions.*

In response to the emerging news that PBAs were being done, the Partial-Birth Abortion Ban Act (H.R. 1833) was introduced in the U.S. Congress in June, 1995. *See Partial-Birth Abortion Ban Act of 1995*, H.R. Rep. No. 104-267 (Sept. 27, 1995). This led to the hearings cited above, which provided an immense amount of legislative evidence on PBA practice.

On December 7, 1995, the U.S. Senate approved the final version of the federal bill by a vote of 54-44. *See* Cong. Rec. S18228, roll call #596 (Dec. 7, 1995). The House of Representatives approved the bill on March 28, 1996, by a vote of 286-129. *See* Cong. Rec. H2929, roll call #94 (Mar. 28, 1996). On April 10, 1996, President Clinton vetoed the bill. *See* Cong. Rec. H3338-3339, H. Doc. 104-198 (Apr. 10, 1996). An override vote in the House obtained the necessary votes for an override, but the vote in the Senate fell short of the two-thirds majority needed. *See* Cong. Rec. H10642, roll call #422 (votes: 285-137) (Sept. 19, 1996); Cong. Rec. S11337-11361, roll call #301 (votes: 57-41) (Sept. 26, 1996).

After the vote, more information about the practice of PBA became available, which altered the debate. For example, Ron Fitzsimmons (head of the National Coalition of Abortion Providers) admitted in an interview with *American Medical News* (and then numerous other news outlets) that he had "lied through his teeth" when he "spouted the party line" on *ABC News Nightline*, by claiming that the annual number of PBAs was only 500 instead of the 3,000 to 5,000 he now admits. *See* Diane M. Gianelli, *Medicine Adds to Debate on Late-Term Abortion: Abortion Rights Leader Urges End to 'Half Truths,'* Am. Med. News, Mar. 3, 1997, at 3, 28; Ruth Padawer, *Pro-Choice Advocates Admit to Deception*, Sunday Record, Feb. 27,

1997; David Stout, *An Abortion Rights Advocate Says He Lied About Procedure*, N.Y. Times, Feb. 26, 1997, at A12.

A PBA bill was reintroduced in Congress, adding the "substantial portion" language that also appears in Nebraska's PBA ban in a further effort to assure that the bill would not chill performance of conventional abortions, thereby gaining the American Medical Association's endorsement. *See infra* note 6. The bill passed the House of Representatives on March 20, 1997, by more than a two-thirds vote, and the Senate on May 20, by a vote of 64-36. *See* Cong. Rec. H1231, roll call #65 (votes: 295-136) (Mar. 20, 1997); Cong. Rec. S4715, roll call #71 (May 20, 1997). The bill was vetoed by the President. *See* Cong. Rec. H8891-8892, H.Doc. 105-158 (Oct. 10, 1997). The House readily overrode the veto, while the Senate fell just short of an override. *See* Cong. Rec. H6212-13, roll call #325 (votes: 296-132) (July 23, 1998); Cong. Rec. S10564, roll call #227 (votes: 64-36) (Sept. 18, 1998). This 1997 bill was the pattern for Nebraska's law.[5]

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[5]That the federal bill and Nebraska's act are in pari materia is self-evident from a comparison of Nebraska's ban with the following 1997 federal model language:

> Sec. 1531 Partial-birth abortions prohibited.
>
> (a) Any physician who, in or affecting interstate or foreign commerce, knowingly performs a partial-birth abortion and thereby kills a human fetus shall be fined under this title or imprisoned not more than two years, or both. This paragraph shall not apply to a partial-birth abortion that is necessary to save the life of a mother whose life is endangered by a physical disorder, illness, or injury. This paragraph shall become effective one day after enactment.
>
> (b)(1) As used in this section, the term 'partial- birth abortion' means an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and

(continued...)

The history of the debates over these bills is illuminating and certain myths advanced in the debates deserve brief note. These myths were part of an organized misinformation campaign by abortion-rights groups, which experienced a serious setback in late January, 1997, with the release of an edition of the Public Broadcasting System media-criticism program *Media Matters*.[6] The program, which examined the press coverage of

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[5](...continued)
completing the delivery.

> (2) As used in this section, the term 'physician' means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the doctor performs such activity, or any other individual legally authorized by the State to perform abortions: Provided, however, that any individual who is not a physician or not otherwise legally authorized by the State to perform abortions, but who nevertheless directly performs a partial-birth abortion, shall be subject to the provisions of this section.
>
> (3) As used in this section, the term 'vaginally delivers a living fetus before killing the fetus' means deliberately and intentionally delivers into the vagina a living fetus, or a substantial portion thereof, for the purpose of performing a procedure the physician knows will kill the fetus, and kills the fetus.

Partial-Birth Abortion Ban Act of 1997, H.R. 1122, 105th Cong., § 1531 (a) & (b) (Oct. 9, 1997).

[6]A videotape of the program was played at a joint congressional PBA hearing in 1997. *See Partial-Birth Abortion: The Truth: Joint Hearing on S. 6 and H.R. 929 Before the Sen. Comm. on the Judiciary and the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 105th Cong. 16 (1997). *Media Matters* described itself as "a series that looks critically at news media performance." The program was hosted by executive editor Alex Jones, a Pulitzer Prize-winning journalist who also hosts National Public Radio's weekly show *On the Media*. The investigation of PBA coverage was reported by Terry Eastland, editor of *Forbes MediaCritic Online*, and produced by two-time Emmy documentary

(continued...)

PBA issues, concluded that portions of the major media had demonstrated serious bias by uncritically adopting the misinformation provided by the abortion-rights advocacy groups on PBAs.

1. Myth #1: PBAs are only done in extreme cases involving serious fetal deformities or threat to the life of the mother.

In the debate over the federal PBA ban, opponents of the ban argued that PBAs are extremely rare and only done "late term" in extreme cases involving serious fetal deformities or threat to the life of the mother. *See, e.g.*, Ann Devroy, *Late-Term Abortion Ban Vetoed*, Wash. Post, Apr. 11, 1996, at A1. As seen from the discussion of the practice of Drs. Haskell and McMahon, *supra*, it is clear that the substantial majority of partial-birth abortions are performed late in the second trimester – before the 27-week mark, but usually after 20 weeks (4½ months) – and the overwhelming majority are performed for purely nonmedical reasons.

2. Myth #2: Banning PBA would jeopardize the health of women.

In the debate over the federal PBA bills, the assertion was often made that PBAs are necessary to protect the health of women. In the Spring of 1997, however, the American Medical Association came out in support of the federal bill to ban PBA, which, as the AMA Executive Vice President said for the Association, is "not medically indicated" and "is not good

[6](...continued)
nominee Joseph Dorman.

medicine."[7]

3. Myth #3: The anesthesia given to the mother kills the baby or renders the baby pain-free before the procedure is done.

Another piece of misinformation asserted by opponents of the federal PBA ban was that the partially-born victim of cranial decompression was either dead or pain free during the procedure as a result of anesthesia given to the mother.[8] This myth was quickly and emphatically debunked by anesthesiologists. *See* Diane M. Gianelli, *Anesthesiologists Question Claims in Abortion Debate*, Am. Med. News, Jan. 1, 1996, at 4; *1995 Senate Hearings* at 225-26 (Letter from Norig Ellison, M.D. (American Society of Anesthesiologists) to Hon.Orrin G. Hatch (Chairman, Sen. Comm. on the Judiciary) (Nov. 22, 1995)).

[7]Letter from P. John Seward, M.D., Executive Vice President, American Medical Association, to U.S. Sen. Rick Santorum (May 19, 1997) ("The American Medical Association (AMA) is writing to support H.R. 1122, 'The Partial-Birth Abortion Ban Act of 1997.' Although our general policy is to oppose legislation criminalizing medical practice or procedure, the AMA has supported such legislation where the procedure was narrowly defined and not medically indicated. . . . Thank you for the opportunity to work with you toward restricting a procedure we all agree is not good medicine.").

[8]Kate Michelman, President of the abortion-rights group NARAL insisted this in numerous fora, including comments on KMOX-AM radio, St. Louis, Mo., on Nov. 2, 1995. This claim was widely accepted and reported as fact in news stories and editorial commentaries (e.g., by Ellen Goodman). Likewise, Planned Parenthood Federation of America distributed to Congress a "fact sheet" signed by Dr. Mary Campbell, Medical Director of Planned Parenthood of Metropolitan Washington, DC, which asserted the claim. *See* Mary Campbell, *H.R. 1833: Medical Questions and Answers* (October, 1995).

4. Myth #4: A fetus is incapable of feeling pain due to lack of development.

Proponents of PBA also asserted that a fetus was not sufficiently developed to experience pain from the procedure, which assertion was quickly rejected by the experts. At Congressional hearings in June, 1995, brain surgeon Robert J. White testified that "[b]y the 20th week of gestation and beyond, the fetus has in place the neurocircuitry to appreciate pain," and that "there are studies that demonstrate even at 8 weeks through 13 weeks[] there's enough neurocircuitry present so that pain and noxious stimuli could be perceived." *Partial-Birth Abortion* at 67. In fact, "some authorities feel that fetuses at this age [beyond 20 weeks] can perceive pain to a greater degree than the adult." *Id.*

D. *Many Pro-Choice Legislators Joined Efforts to Ban PBA.*

PBA bills in Congress passed by margins much larger than would be possible if only those who identified themselves as pro-life were voting in support. *See supra* I.C. Many who identified themselves as pro-choice supported the PBA bans.

Examples include House Democratic Leader Rep. Richard Gephardt and Sen. Patrick Leahy, who voted to override the President's veto. *See*, *e.g.*, Letter from Rep. Richard A. Gephardt to C.J. Vennemann, Jr. (August 2, 1996) (on file with Amici counsel) ("You may be assured that I will continue to oppose this late-term abortion procedure and vote to override the Presidential veto when this again comes to the House Floor."); Cong. Rec. S11356 (Sen. Leahy: "[m]y conscience alone, must determine my vote. I will vote to override."). In his speech in favor of overriding the President's veto, Sen. Specter declared that his vote did "not affect [his] basic views on the

pro-choice/pro-life issue," but that "the line of the law is drawn, in [his] legal judgment, when the child is partially out of the womb of the mother. It is no longer abortion; it is infanticide." Cong. Rec. S11375.

Normally pro-choice Sen. Daniel Patrick Moynihan also voted to override the President's veto, and was quoted as follows: "At the time, I remarked that the procedure was too close to infanticide . . . and now we have testimony that it is not just too close to infanticide, it is infanticide, and one would be too many." Congressional Quarterly, *Moynihan: Clinton turnabout likely Senator says veto OK'd infanticide*, CQ's Washington Alert, March 15, 1997, Item 1 at 2.

This support from abortion-rights supporters indicates both (1) that the PBA bans do not target conventional abortion procedures and (2) that for many who support abortion rights PBA is not what they mean by "abortion."

E. *Recent Senate Action Reveals Support for Abortion Rights But Opposition to PBA.*

Recently, the Senate passed S. 1692, another bill banning PBA. *See* Cong. Rec. S12997, roll call #340 (votes: 63-34) (Oct. 21, 1999). It reveals precisely the point made in this brief, namely, there is ongoing opposition to PBA amid congressional support for abortion rights.

The Senate bill was modified to assure that the language banning PBA does not reach the dilation and evacuation (D&E) and other conventional abortion procedures. It also contained three statements of the sense of Congress.

The first, a "Sense of Congress Concerning Roe v. Wade and Partial Birth Abortion Bans," stated the following:

(a) FINDINGS – Congress finds that –

(1) abortion has been a legal and constitutionally protected medical procedure . . . since the Supreme Court decision in Roe v. Wade . . .; and

(2) no partial birth abortion ban shall apply to a partial-birth abortion that is necessary to save the life of a mother whose life is endangered by a physical disorder, illness, or injury.

(b) SENSE OF CONGRESS – It is the sense of the Congress that partial-birth abortions are horrific and gruesome procedures that should be banned.

Id. at § 3.

The second, a "Sense of the Congress Concerning a Woman's Life and Health," provided as follows:

(a) It is the sense of the Congress that, consistent with the Supreme Court, a woman's life and health must always be protected in any reproductive health legislation passed by Congress.

Id. at § 4.

The third, a "Sense of the Congress Concerning Roe v. Wade," made the following statement:

(a) FINDINGS – Congress finds that –

(1) reproductive rights are central to the ability of women to exercise their full rights under Federal and State law;

(2) abortion has been a legal and constitutionally protected medical procedure . . . since the Supreme Court decision in Roe . . .;

(3) the 1973 Supreme Court decision in Roe v. Wade

established constitutionally based limits on the power of States to restrict the right of a woman to choose to terminate a pregnancy; and

(4) women should not be forced into illegal and dangerous abortions as they often were prior to the Roe v. Wade decision.

(b) SENSE OF THE CONGRESS – It is the sense of the Congress that –

(1) Roe v. Wade was an appropriate decision and secures an important constitutional right; and

(2) such decision should not be overturned.

Id. at § 5.

Again it is evident both that (1) PBA bans do not target conventional abortion procedures and (2) for many who support abortion rights "abortion" does not include PBA. It would be a radical extension of *Casey* to expand it to reach a partial-birth killing procedure that Congress (along with most Americans and States) does not even consider to be "abortion."

II. The Legal Premise of Federal and State Partial-Birth Abortion Bans Is That This Court's Abortion Jurisprudence Does Not Apply During Parturition, But Even if it Does Such Bans Comport with That Jurisprudence.

The federal PBA bills, upon which Nebraska's ban and most other state bans are modeled, were premised in part on the belief that this Court's abortion jurisprudence does not govern a statute involving partial-birth or parturition, but, even if it does govern, there is no "undue burden" on the abortion right.

See H.R. Rep. No. 104-267, at 9 (1995)[9] (the report of the House Committee on the Judiciary recommending passage of Partial-Birth Abortion Ban Act of 1995); *The Partial Birth Abortion Ban Act of 1995: Hearings on H.R. 1833 Before the Sen. Comm. on the Judiciary*, 104th Cong. 172 (Nov. 17, 1995) (written Testimony of Prof. Douglas W. Kmiec).

A. *This Court's Decisions Regarding the Right to Abort "Unborn Children" Do Not Apply to Laws that Prohibit the Killing of Partially-Born Children.*

The belief that this Court's abortion jurisprudence does not apply to a PBA statute arises from the fact that the constitutional equation has changed with the changed location of the child. The abortion right involves an "unborn" human being (not one partially born) and the termination of a pregnancy (which arguably has ended when a child is partially delivered). Therefore, there could be no "undue burden" under a *Casey* analysis because a *Casey* analysis would not apply.

This Court's own decisions reflect the fact that the constitutional balance is affected by the partial birth of the

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[9]The twelve-page report discussed the constitutionality of the partial-birth abortion ban under various levels of scrutiny. It declared that:

> This Supreme Court has never decided the constitutional status of a child in the process of being born. But even under *Roe v. Wade* and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, H.R. 1833, the "Partial-Birth Abortion Ban Act of 1995," is constitutional both before and after fetal viability. . . . In fact, in *Roe* this Court specifically noted that a Texas statute that made killing a child during the birth process a felony had not been challenged. . . .

Partial-Birth Abortion Ban Act of 1995, H.R. Rep. No. 104-267, at 9 (Sep. 27, 1995).

child. In *Roe v. Wade*, 410 U.S. 113 (1973), this Court held that the Texas anti-abortion statute at issue was unconstitutional, but the Court also noted that another Texas statute that bans killing children in parturition was unchallenged and unaffected. As quoted by the Court, this statute provides as follows:

> Art. 1195. Destroying unborn child. – Whoever shall during parturition of the mother destroy the vitality or life in a child in a state of being born and before actual birth, which child would otherwise have been born alive, shall be confined in the penitentiary for life or for not less than five years.

Id. at 118 n.1. The Texas parturition statute remains operative. Tex. Rev. Civ. Stat. Ann. art. § 4512.5 (West 1996). *See* Tex. Att'y Gen. Opinion H-369 (Aug. 13, 1974) (Texas parturition statute unaffected by *Roe)*; *Showery v. Texas*, 690 S.W.2d 689, 692 (Tex. Ct. App. 1985) (Texas parturition statute retains "current viability").[10]

If abortion jurisprudence does not apply in situations where a child is partially born, PBA bans must be upheld as rationally related to legitimate State interests unless this Nation's history and traditions have recognized a fundamental right to kill a partially born child. *See Washington v. Glucksberg*, 521 U.S. 702, 720 (1997). The Texas parturition statute illustrates that no such right has ever been recognized. There being no fundamental right, the State can readily demonstrate that a ban on killing children in parturition is rationally related to a legitimate state interest, *see infra*, and the PBA ban

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[10]The plain language of the Texas law requires only that the child in parturition "would otherwise have been born *alive*," not that the child be "*viable*." The partial-birth abortion statutes likewise are not limited to viable children.

must be upheld.

B. *Even if this Court's Abortion Decisions Apply, Partial-Birth Abortion Bans Further the Heightened Governmental Interest in Protecting Partially-Born Children and Do Not Place an Undue Burden on Any Abortion Right.*

The partial-birth abortion bans are based on the premise that States have a compelling interest in protecting the actual life of a child in the process of birth that is greater than, and distinguishable from, a state's interest in the "potential life" of a fetus in utero, which this Court has termed "substantial." *Casey*, 505 U.S. at 876. As the Wisconsin District Court found,

> when the physician kills a child in a partial birth abortion, the child "is merely inches from being delivered and obtaining full legal rights of personhood under the US Constitution." Accordingly, . . . partial birth abortion is "closer to infanticide than it is to abortion." The [Wisconsin State] legislators who filed an amicus brief [in the District Court] make similar arguments. The Court concludes that these facts demonstrate that the Act serves compelling state interests.

Planned Parenthood of Wis. v. Doyle, 44 F. Supp. 2d 975, 982 (W.D. Wis. 1999) (citations omitted).

It logically follows from this Court's abortion decisions that the interest in protecting the life of the child in the process of birth arises from the change of legal status the fetus undergoes as she changes location, emerging from the maternal body toward complete birth. *Roe* affirmed the constitutional significance of the locational change that occurs as the child emerges from the maternal body.

The child who has been completely born is a fully legal person, and the abortion liberty can make no claim on such a child's life. *See Roe*, 410 U.S. at 156-57. Similarly, it follows that the child who is partially born is the subject of a compelling state interest, and any asserted abortion liberty holds, at most, diminished power over such a child.

This is evident from examination of common definitions. "Birth" is "1.a. The emergence and separation of offspring from the body of the mother. b. The act or *process* of bearing young, parturition" *American Heritage College Dictionary* 141 (1993) (emphasis added); *see also Black's Law Dictionary* 154 (5th ed. 1979) ("Birth" is "*[t]he act of being born* or wholly brought into separate existence.") (emphasis added); *id.* at 167 ("Born" is the "*[a]ct of being delivered* or expelled from mother's body, whether or not placenta has been separated or cord cut.") (emphasis added).

These definitions clearly apply to a child who has fully emerged from her mother's body – she is obviously "born." But they also apply to a child in the "*process*" of "being born," in the *"act of being delivered,"* who also falls within these common definitions of "birth" and "born." Therefore, Nebraska (and Congress) may properly conclude that such a child is no longer "unborn" – no longer under the sway of the *Casey* abortion liberty – and that the State has a heightened interest in protecting the life of the partially-born child.

This Court has acknowledged that a State's interest in the life of a fetus grows as the fetus becomes able to survive apart from the mother's body – as the fetus becomes "viable." *See Roe*, 410 U.S. at 163-64; *Casey*, 505 U.S. at 875-76. Likewise, a State's interest in protection of the life of an unborn child increases and becomes compelling as she emerges from the maternal body and proceeds toward full birth, reaching its

apogee when live birth is completed. As the length of gestation has jurisprudential significance, so does location, and it is on the basis of the child's change in *location* that governments may assert a distinct compelling interest in protection of human life in the process of birth.

In the typical intact D&X abortion – the only procedure to which a properly construed partial-birth abortion statute applies – the child is delivered in a breech position, and only the child's head remains within the uterus. Much of the remainder of the child's body exists entirely outside the body of the woman. *See* Report of the AMA Board of Trustees ("One feature that distinguishes the D&X procedure from other destructive procedures is that the fetus may be partly outside the woman's body."). Surely, a State may conclude that such a child is no longer "unborn" and that the process of birth has proceeded to such a point that a state's interest in protection of the child has become compelling. "[T]he State cannot be faulted for acting where it can to outlaw an unnecessary procedure that in most cases in which it is used is literally inches away from being infanticide." *Doyle*, 44 F. Supp. 2d at 984.

Certainly, there is no precedent from this Court and there is no explicit language in the Constitution that precludes a State from determining that a child in the process of birth warrants special protection as the subject of a compelling state interest. This Court has simply not addressed the issue.

Nor has this Court held that gestational development/viability are the *exclusive* criteria by which the Constitution allows the State to measure its interest in the protection of human life. "Although abortion laws are typically justified according to the state's interest in maternal health or potential life, the *Casey* court specifically recognized that 'other valid state interest[s]' could justify a pre-viability abortion restric-

tion.'" *Doyle*, 44 F. Supp. 2d at 983 (quoting *Casey*, 505 U.S. at 877). In fact, it would be absurd to posit that the mere potential to live outside the womb – viability – has constitutional significance, while the actual fact of emergence of a living child from the womb has none whatever.

In short, a State may assert a distinct compelling interest in the protection of children in the process of birth that would overcome even a fundamental right to choose abortion. This locational interest exists apart from the substantial and compelling interests that the State might properly assert in "potential" human life based on gestational development, and it warrants special protection of the partially-born child.

And just as the fully born child – whether "viable" or not – is the subject of a compelling governmental interest in the protection of the child's life, based solely on the locational change the child has undergone, so also the child in the process of birth – whether "viable" or not – is the subject of a compelling state interest by virtue of the child's change in location

Furthermore, the abortion right wanes as a State's interest in protecting a partially born child waxes. This Court has recognized only a right to terminate pregnancy. *See Casey*, 505 U.S. at 847. This right authorizes a pregnant woman to seek the means to terminate her pregnancy without State interference that unduly burdens her decision. *See id.* at 876-77. What are the outer boundaries of this right? Certainly, they do not extend beyond the maternal body. A woman seeking an abortion could not claim that this right authorizes killing a child who survives an abortion procedure and is born alive.

Partial-birth abortion bans build upon this understanding of the abortion liberty. The bans acknowledge that pregnancy may be terminated under this Court's precedent, but deny that

it may be terminated in a manner that purposefully seeks to kill the child once the child has begun the process of birth, a process marked by the passage of the living child's body from womb into birth canal to outside the woman's body. At this point, any claim of a right to terminate pregnancy is substantially obviated as pregnancy is terminated. The power and dominion of the abortion liberty diminish as its purpose is achieved and the child is delivered. Since the right to abortion does not include an independent right to assure fetal death, the abortion liberty cannot be asserted to justify a separate act to kill the child as the child proceeds out of the maternal body.

In sum, just as a State's interest in protecting the child increases as the child proceeds toward birth, the woman's right to abortion diminishes as the child leaves the maternal body. Partial-birth abortion bans implement this understanding and further the government's compelling interest in protecting the lives of partially-born children.

Moreover, PBA bans do not impose an undue burden on women seeking abortions because the PBA procedure is never medically indicated; a PBA ban leaves in place conventional abortion procedures; and PBA bans promote the important state interest in protecting maternal health. "After a trial, the district court in the Wisconsin case concluded that the intact D&X procedure is never necessary from the perspective of the patient's health." *Hope Clinic v. Ryan*, 195 F.3d 857, 872 (7th Cir. 1999) (citing *Doyle*, 44 F. Supp. 2d at 979-82). As the AMA declared, PBA is "not medically indicated" and "not good medicine." Letter from P. John Seward, M.D., Executive Vice President, American Medical Association, to U.S. Sen. Rick Santorum (May 19, 1997). Even the American College of Obstetricians and Gynecologists could not identify a situation in which PBA would be the only medically appropriate option.

See Hope Clinic, 195 F.3d at 872. The Seventh Circuit declared that "[w]e proceed on the assumption, which appears to be shared by the American Medical Association, that the D&X is not the best or safest option in any articulable category of situations." *Id.*

This has also been the conclusion of those supporting a federal PBA in Congress. In a 1995 report by the House Committee on the Judiciary, the legal analysis was stated as follows:

> After viability, the government under both *Roe* and *Casey* may prohibit all abortion, except those that are necessary to save the life or health of the mother. Therefore, the government can clearly prohibit partial-birth abortion, a method of abortion preferred by only a handful of abortionists [footnote omitted] that is particularly offensive to humanity. H.R. 1833 leaves alternative procedures, including other methods of abortion, available for a physician to use in a case where a mother's life or health is threatened by bringing her child to term.
>
> Before viability, *Casey* allows regulation of abortion that is reasonably related to a legitimate state interest, unless the regulation places an "undue burden" on a woman's right to choose to have an abortion. [footnote omitted]
>
> The [Act] does not place a "substantial obstacle" in the path of a mother seeking to abort her child. The Act prohibits only abortions in which the child is partially delivered alive and then killed. It does not prohibit alternative, and, in fact, more frequently used late-term abortion techniques. Partial-birth abortions are not performed due to any special circumstances of a mother or her pregnancy.

The procedure is used by a handful of abortionists who "routinely" perform the procedure in late pregnancy. [footnote omitted]

Banning this particularly heinous procedure does not place an "undue burden" on a mother's right to choose to have an abortion. Since [the Act] does not impose an "undue burden," rational basis scrutiny is applied to determine whether [the Act] is constitutional.

. . . .

[The Act] serves several legitimate governmental interests some of which are mentioned above. Among the important interests served by banning partial-birth abortion is the government's interest in protecting human life. During a partial-birth abortion a child is killed after she is partially delivered from her mother's womb. The difference between partial-birth abortion and infanticide is a mere three inches. The [Act] would protect children from being killed in the delivery process.

The Act also serves the interest of protecting the dignity of human life. . . . Allowing an abortionist to kill a child in this manner reduces society's respect for human life.

An additional legitimate interest is the prevention of both moral and legal confusion about the role of physicians in our society. . . . In a partial-birth procedure, the child's life is taken during a breach delivery. A procedure which obstetricians use in some circumstances to bring a healthy child into the world is perverted to result in a dead child. The physician, traditionally trained to do everything in his power to assist and protect both mother and child during the birth process deliberately kills the child in the

birth canal. A doctor holding a child in the palm of his hand and deliberately killing that child offends society's concept of the role of a physician. The [Act] would put an end to this heinous act.

The prevention of cruel and inhumane treatment is another interest furthered by the [Act]. . . .

[The Act] is reasonably related to these and other legitimate government interests[, which become cognizable because of the change in the child' location]. The [Act] is constitutionally permissible and morally imperative.

Partial-Birth Abortion Ban Act of 1995, H.R. Rep. No. 104-267, at 9 (Sep. 27, 1995).

CONCLUSION

Amici Curiae request this Court to reverse the decision of the Eighth Circuit and uphold the constitutionality of the Nebraska partial-birth abortion ban.

Respectfully submitted,

James Bopp, Jr.
Richard E. Coleson
Counsel of Record
Thomas J. Marzen
BOPP, COLESON & BOSTROM
1 South 6th Street
Terre Haute, IN 47807-3510
(812) 232-2434
Counsel for Amici Curiae

APPENDICES

A. Dr. Martin Haskell's Monograph

From *Partial-Birth Abortion: The Truth: Joint Hearing on S. 6 and H.R. 929 Before the Sen. Comm. on the Judiciary and the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 105th Cong. 56 (1997).

B. Partial-Birth Abortion Drawing

From *The Partial-Birth Abortion Ban Act of 1995: Hearing on H.R. 1833 Before the Senate Comm. on the Judiciary*, 104th Cong. 3 (Nov. 17, 1995).

App. 1

Second Trimester Abortion:
From Every Angle
Fall Risk Management Seminar
September 13-14, 1992
Dallas, Texas

Pesentations, Bibliography & Related Materials

[NATIONAL ABORTION FEDERATION LOGO] 1992

Dilation and Extraction for Late Second Trimester Abortion

Martin Haskell, M.D.

Presented at the National Abortion Federation
Risk Management Seminar, September 13, 1992

INTRODUCTION

The surgical method described in this paper differs from classic D&E in that it does not rely upon dismemberment to remove the fetus. Nor are inductions or infusions used to expel the intact fetus.

Rather, the surgeon grasps and removes a nearly intact fetus through an adequately dilated cervix. The author has coined the term *Dilation and extraction or D&X* to distinguish is from dismemberment-type D&E's.

This procedure can be performed in a properly equipped physician's office under local anesthesia. It can be used successfully in patients 20-26 weeks in pregnancy.

The author has performed over 700 of these procedures with a low rate of complications.

BACKGROUND

D&E evolved as an alternative to induction or instillation methods for second trimester abortion in the mid 1970's. This happened in part because of lack of hospital facilities allowing second trimester abortions in some geographic areas, in part because surgeons needed a "right now" solution to complete suction abortions inadvertently started in the second trimester and in part to provide a means of early second trimester abortion to avoid necessary delays for instillation methods.[1] The North Carolina Conference in 1978 established D&E as the preferred method for early second trimester abortions in the U.S.[2,3,4]

Classic D&E is accomplished by dismembering the fetus inside the uterus with instruments and removing the pieces through an adequately dilated cervix.[5]

However, most surgeons find dismemberment at twenty weeks and beyond to be difficult due to the toughness of fetal tissues at this stage of development. Consequently, most late second trimester abortions are performed by an induction method.[6,7,8]

Two techniques of late second trimester D&E's have been described at previous NAF meetings. The first relies on sterile urea intra-amniotic infusion to cause fetal demise and lysis (or softening) of fetal tissues prior to surgery.[9]

The second technique is to rupture the membranes 24 hours prior to surgery and cut the umbilical cord. Fetal death and ensuing autolysis soften the tissues. There are attendant risks of infection with this method.

In summary, approaches to late second trimester D&E's rely upon some means to induce early fetal demise to soften the fetal tissues making dismemberment easier.

PATIENT SELECTION

The author routinely performs this procedure on all patients 20 through 24 weeks LMP with certain exceptions. The author performs the procedure on selected patients 25 through 26 weeks LMP.

The author refers for induction patients falling into the following categories:

Previous C-section over 22 weeks
Obese patients (more than 20 pounds over large frame ideal weight)
Twin pregnancy over 21 weeks
Patients 26 weeks and over

DESCRIPTION OF DILATION AND EXTRACTION METHOD

Dilation and extraction takes place over three days. In a nutshell, D&X can be described as follows:

Dilation
MORE DILATION
Real-time ultrasound visualization
Version (as needed)
Intact extraction
Fetal skull decompression
Removal
Clean-up
Recovery

Day 1 – Dilation

The patient is evaluated with an ultrasound, hemoglobin and Rh. Hadlock scales are used to interpret all ultrasound measurements.

In the operating room, the cervix is prepped, anesthetized and dilated to 9-11 mm. Five, six or seven large Dilapan hydroscopic dilators are placed in the cervix. The patient goes home or to a motel overnight.

Day 2 – More Dilation

The patient returns to the operating room where the previous day's Dilapan are removed. The cervix is scrubbed and anesthetized. Between 15 and 25 Dilapan are placed in the cervical canal. The patient returns home or to a motel overnight.

Day 3 – The Operation

The patient returns to the operating room where the previous day's Dilapan are removed. The surgical assistant administers 10 IU Pitocin intramuscularly. The cervix is scrubbed, anesthetized and grasped with a tanaculum. The membranes are ruptured, if they are not already.

The surgical assistant places an ultrasound probe on the patient's abdomen and scans the fetus, locating the lower extremities. This scan provides the surgeon information about the orientation of the fetus and approximate location of the lower extremities. The tranducer is then held in position over the lower extremities.

The surgeon introduces a large grasping forcep, such as Bierer or Hern, through the vaginal and cervical canals into the corpus of the uterus. Based upon his knowledge of fetal orientation, he moves the tip of the instrument carefully towards the fetal lower extremities. When the instrument appears on the sonogram screen, the surgeon is able to open and close its jaws to firmly and reliably grasp a lower extremity. The surgeon then applies firm traction to the instrument causing a version of the fetus (if necessary) and pulls the extremity into the vagina.

By observing the movement of the lower extremity and version of the fetus on the ultrasound screen, the surgeon is assured that his instrument has not inappropriately grasped a maternal structure.

With a lower extremity in the vagina, the surgeon uses his fingers to deliver the opposite lower extremity, then the torso, the shoulders and the upper extremities.

The skull lodges at the internal cervical os. Usually there is not enough dilation for it to pass through. The fetus is oriented dorsum or spine up.

At this point, the right-handed surgeon slides the fingers of the left had [sic] along the back of the fetus and "hooks" the shoulders of the fetus with the index and ring fingers (palm down). Next he slides the tip of the middle finger along the spine towards the skull while applying traction to the shoulders and lower extremities. The middle finger lifts and pushes the anterior cervical lip out of the way.

While maintaining this tension, lifting the cervix and applying traction to the shoulders with the fingers of the

left hand, the surgeon takes a pair of blunt curved Metzenbaum scissors in the right hand. He carefully advances the tip, curved down, along the spine and under his middle finger until he feels it contact the base of the skull under the tip of his middle finger.

Reassessing proper placement of the closed scissors tip and safe elevation of the cervix, the surgeon then forces the scissors into the base of the skull or into the foramen magnum. Having safely entered the skull, he spreads the scissors to enlarge the opening.

The surgeon removes the scissors and introduces a suction catheter into this hole and evacuates the skull contents. With the catheter still in place, he applies traction to the fetus, removing it completely from the patient.

The surgeon finally removes the placenta with forceps and scrapes the uterine walls with a large Evans and a 14 mm suction curette. The procedure ends.

Recovery

Patients are observed a minimum of 2 hours following surgery. A pad check and vital signs are performed every 30 minutes. Patients with minimal bleeding after 30 minutes are encouraged to walk about the building or outside between checks.

Intravenous fluids, pitocin and antibiotics are available for the exceptional times they are needed.

ANESTHESIA

Lidocaine 1% with epinephrine administered *intra*-cervically is the standard anesthesia. Nitrous-oxide/oxygen analgesia is administered nasally as an adjunct. For the Dilapan insert and Dilapan change, 12cc's is used in 3 equidistant locations around the cervix. For the surgery, 24cc's is used at 6 equidistant spots.

Carbocaine 1% is substituted for lidocaine for patients who expressed lidocaine sensitivity.

MEDICATIONS

All patients not allergic to tetracycline analogues receive doxycycline 200 mgm by mouth daily for 3 days beginning Day 1.

Patients with *any* history of gonorrhea, chlamydia or pelvic inflammatory disease receive additional doxycycline, 100mgm by mouth twice daily for six additional days.

Patients allergic to tetracyclines are not given proplylactic [sic] antibiotics.

Ergotrate 0.2 mgm by mouth four times daily for three days is dispensed to each patient.

Pitocin 10 IU intramuscularly is administered upon removal of the Dilapan on Day 3.

Rhogam intramuscularly is provided to all Rh negative patients on Day 3.

Ibuprofen orally is provided liberally at a rate of 100 mgm per hour from Day 1 onward.

Patients with severe cramps with Dilapan dilation are provided Phenergan 25 mgm suppositories rectally every 4 hours as needed.

Rare patients require Synalogos DC in order to sleep during Dilapan dilation.

Patients with a hemoglobin less than 10 g/dl prior to surgery receive packed red blood cell transfusions.

FOLLOW-UP

All patients are given a 24 hour physician's number to call in case of a problem or concern.

At least three attempts to contact each patient by phone one week after surgery are made by the office staff.

All patients are asked to return for check-up three weeks following their surgery.

THIRD TRIMESTER

The author is aware of one other surgeon who uses a conceptually similar technique. He adds additional changes of Dilapan and/or lamineria in the 48 hour dilation period. Coupled with other refinements and a slower operating time, he performs these procedures up to 32 weeks or more.[10]

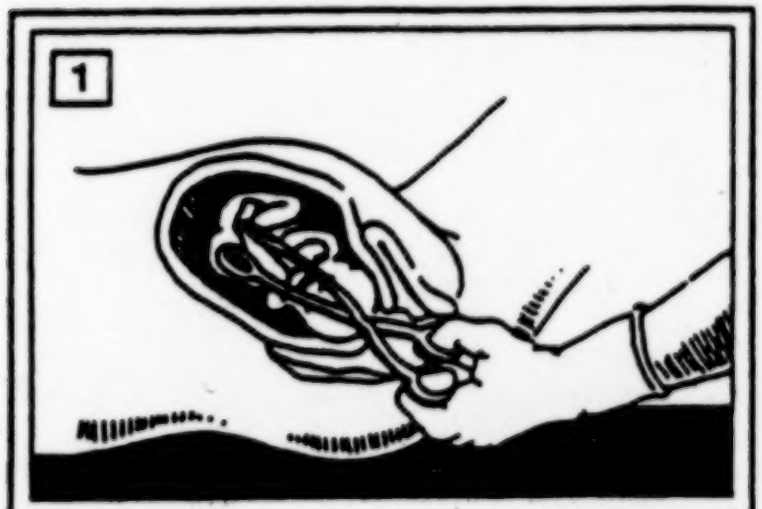
SUMMARY

In conclusion, Dilation and Extraction is an alternative method for achieving late second trimester abortions to 26 weeks. It can be used in the third trimester.

Among its advantages are that it is a quick, surgical outpatient method that can be performed on a scheduled basis under local anesthesia.

Among its disadvantages are that it requires a high degree of surgical skill, and may not be appropriate for a few patients.

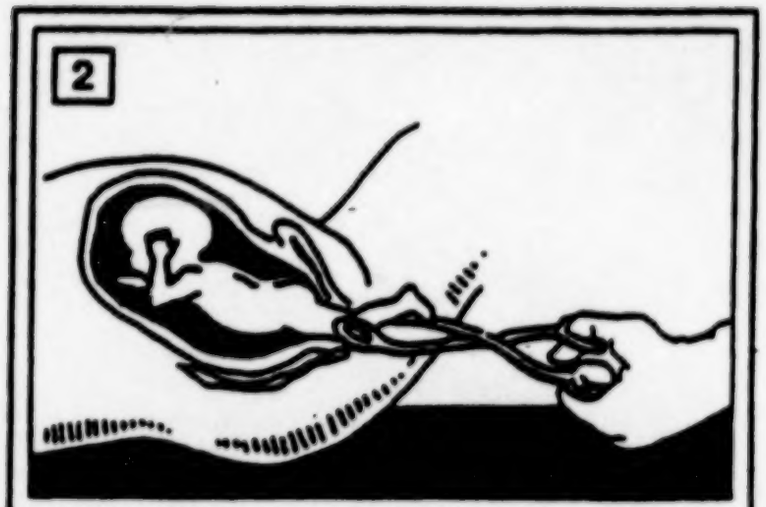
PARTIAL-BIRTH ABORTION



Guided by ultrasound, the abortionist grabs the baby's leg with forceps.

Appendix B

From *Partial-Birth Abortion: The Truth: Joint Hearing on S. 6 and H.R. 929 Before the Sen. Comm. on the Judiciary and the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 105th Cong. 56 (1997).



The baby's leg is pulled out into the birth canal.

The abortionist delivers the baby's entire body, except for the head.

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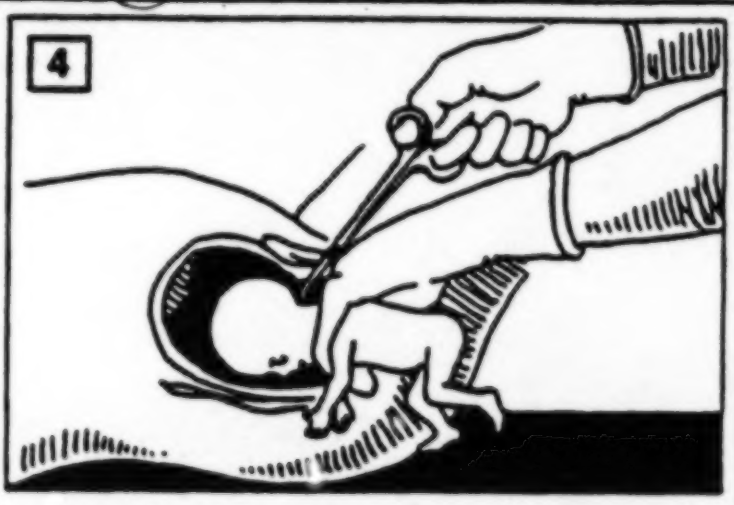
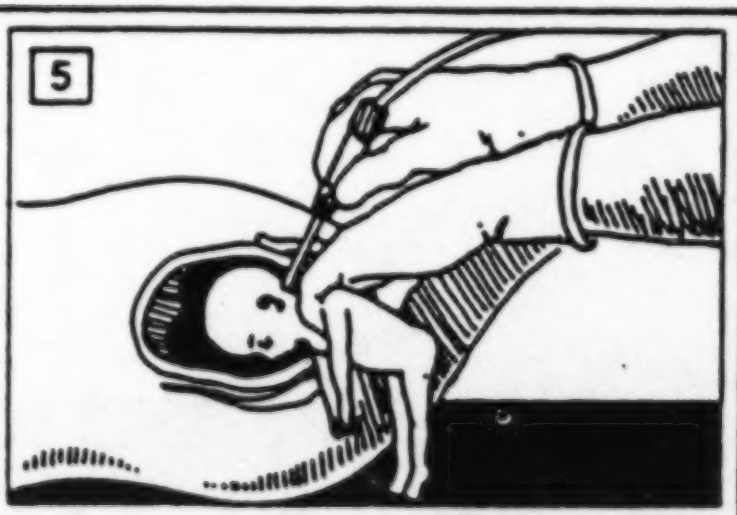


The abortionist jams scissors into the baby's skull. The scissors are then opened to enlarge the hole.



The scissors are removed and a suction catheter is inserted. The child's brains are sucked out, causing the skull to collapse. The dead baby is then removed.